DATE: ________________

PATIENT NAME: ______________________________________ Age _______________

NAME AND ADDRESS OF REFERRING PHYSICIAN: _____________________________________
____
PRIMARY CARE PHYSICIAN NAME AND ADDRESS _____________________________________
____

New Patient Information Form Related to Cervical Spine

Is this visit related to a recent motor vehicle accident? _________ If so, date of accident: ________________
Is this visit due to a work-related injury? __________ If so, date of injury: ___________________________

Note: You may use the back of this paper if you need additional space.
When did you first notice any neck and/or arm pain? ____________________________.

Describe how the problem began: ____
____
____

When did you first go to a doctor or chiropractor for this problem? What kinds of tests or treatment were ordered? ____
____

Were you referred to any other physicians for further tests or treatment? ( ) Yes ( ) No
If so, who were you referred to and what was recommended? ________________________________
____
____

What things do you do that make the problem better (sitting, lying down, etc.)?____________________
____
____

What things do you do that makes the problem worse (standing, walking, bending, etc.)? _____________
____
____

What type of treatment has helped? ____
____

Has your condition changed since the pain began? ( ) Improved ( ) Became worse ( )No change

Has any Doctor recommended surgery for this condition? ǐ Yes ǐ No

I have had the following tests for my neck pain:
_____ MRI _____Myelogram ______CT Scan ______Bone Scan
_____ EMG _____Discogram ______Regular X-rays ______Date of Testing
_____ Nerve Conduction Studies

Current Symptoms:

_____ I have only neck pain.
_____ I have only arm pain.
_____ I have neck and arm pain; which one is worse? ( ) Neck ( ) Arm ( ) Both about equal.
Have you had any changes in your handwriting? ( ) Yes ( ) No. If so, when? ____________
Have your noticed any weakness in your hand or arm? ( ) Yes ( ) No
Do you have any problem with coordination, such as buttoning buttons or zipping zippers?
( )Yes ( ) No
Have you totally lost control of your bladder? ( ) Yes ( ) No Explain:__________________

Limitations (Check one):

Sitting:
I can sit as long as I like with without pain______
Pain prevents me from sitting for more than one hour______
Pain prevents me from sitting for more than thirty minutes______
Pain prevents me from sitting for more than 10 minutes ______

Standing:
I can stand as long as I like without extra pain______
Pain prevents me from standing for more than one hour _______
Pain prevents me from standing for more than thirty minutes______
Pain prevents me from standing for more than 10 minutes______
Pain prevents me from standing at all______

Walking:
I can walk any distance without limitation______
Pain prevents me from walking for more than one mile ______
Pain prevents me from walking for more than ½ mile______
Pain prevents me from walking for more than ¼ mile______
I can only use a cane or walker ______
I am in bed most of the time and have to crawl to the bathroom_____

Lying:
Does lying down in bed increase your neck pain? ______
Does lying down in bed decrease your neck pain? ______
Do you wake up at night with pain while changing positions? ______

Social:
My social life is normal ______
My social life is affected because of pain______
I have no social life because of pain______

Medical History

( ) AIDS/HIV
( ) Anxiety
( ) Arthritis ( ) Degenerative ( ) Rheumatoid ( ) Gout ( ) Other:_________________
( ) Bladder Disorder
( ) Blood Disorder ( ) Anemia ( ) Leukemia ( ) Bleeding Tendency ( ) Other: ____________
( ) Blood clots in legs
( ) Cancer Type and Sites:____
( ) Depression
( ) Diabetes
( ) Headaches
( ) Head injury
( ) Hearing disorder
( ) Heart Disease ( ) Angina ( ) Heart Attack ( ) Heart Failure
( ) Hepatitis
( ) High Blood Pressure
( ) Joint Disease
( ) Kidney Disease ( ) Stones ( ) Infections ( ) Other:______________________
( ) Liver Disease ( ) Hepatitis ( ) Type A ( ) Type B ( ) Other:____________
( ) Lung Disease ( ) Emphysema ( ) TB ( ) Chronic Bronchitis ( ) Cancer ( ) Asthma
( ) Seizure Disorder

Medical History continued,
( ) Stomach Disorder
( ) Thyroid Disease
( ) Tinnitus (ringing in ears)
( ) Ulcers
( ) Vascular Disease
( ) Weight changes :____
( ) Psychological Difficulties: ( ) Depression ( ) Psychosis ( ) Other:_________________

Previous Surgeries: ( ) No previous surgeries
Year
_____ ( ) Tonsillectomy _____ ( ) Hysterectomy ( ) Total ( ) Partial
_____ ( ) Appendectomy _____ ( ) Prostate Operation
_____ ( ) Gallbladder _____ ( ) Biopsy (Type – Result)____________________
_____ ( ) Hernia Repair _____ ( ) Fractures (Explain)______________________
_____ ( ) Vasectomy (Males) _____ ( ) Other:________________________________

Allergies: (Circle the reaction that applies)

( ) Penicillin	Rash	Breathing Problems	Nausea/Vomit	Required Hospitalization
( ) Sulfe	Rash	Breathing Problems	Nausea/Vomit	Required Hospitalization
( ) Keflex	Rash	Breathing Problems	Nausea/Vomit	Required Hospitalization
( ) Codeine	Rash	Breathing Problems	Nausea/Vomit	Required Hospitalization
( ) Latex	Rash	Breathing Problems	Nausea/Vomit	Required Hospitalization

( ) Other: _______________
( ) None

List all current medication, including vitamins and herbs ____________________________
____
____

Social History

Current tobacco use □ Yes □ No. If cigarettes, ______# of packs daily (cigarettes, Cigars, Pipe, Chew tobacco)

Alcohol use ( )Yes ( )No _____________# drinks daily # of drinks every week________________

Living situation/marital status: ( ) Married ( ) Single ( ) Widow(er) ( ) Divorced ( ) Live alone ( ) Have roommate

Work Status:
Occupation: ______________________________
( ) Work full-time ( ) Work part-time ( ) Work but with restrictions

Job requirements are:

( ) Heavy	Lifting over 60 lbs and frequent bending and stooping
( ) Medium	Lifting 30-50 lbs
( ) Light	Lifting 10-20 lbs
( ) Sedentary	Sit most of the time and very little lifting

( ) Not working due to pain ( ) Not working for other reasons. Explain:___________________________
____

Do you live in a one story or two story home or apartment? _______________

Medications
( ) Aspirin ( ) Tylenol ( ) Sleeping Meds:______________________
( ) Muscle Relaxors ( ) Anti-Inflammatories:________________________
( ) Codeine
( ) Anti-Depressants ( ) Anti-psychotics
( ) Others:____

Dr. B. Christoph Meyer, P.A.
8200 Wednesbury, Suite 360
Houston, Texas 77074

Neck Pain Questionnaire

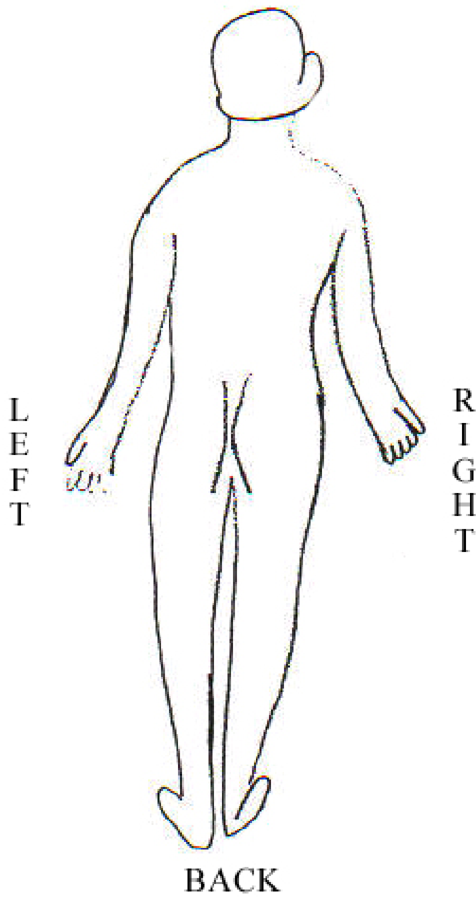
Patient Name:_______________________________________ Date:_________________

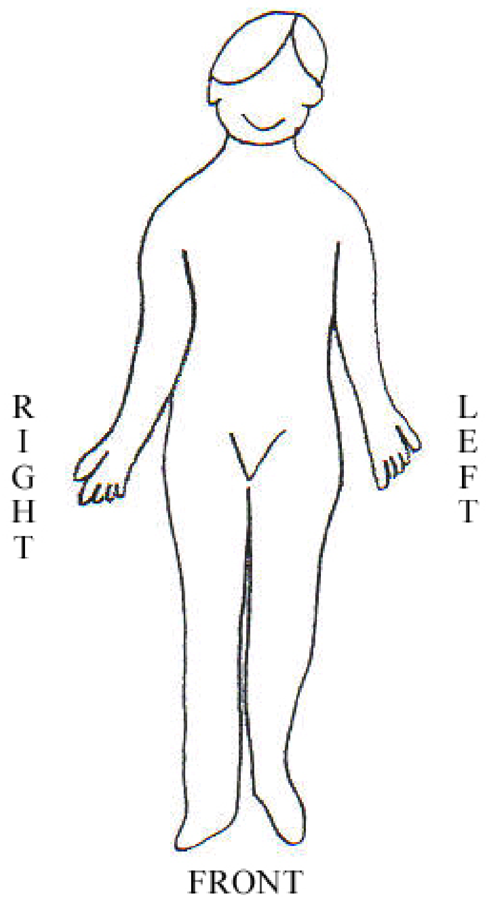
No Pain		Low		Moderate		Intense		Unbearable		
0	1	2	3	4	5	6	7	8	9	10

Pain level now______ Least pain in the last month_______ Most pain in the last year_______

Indicate the location and type of your pain in the drawing below using the following symbols:

OO Pins and Needles
XX Burning
// Stabbing
= Numbness
’’’’ Aching





Office Notes:____
____
____
____

Welcome to the **Houston Center for Spinal Reconstruction and Disc Replacement**. In order for us to be able to deliver the quality of care that you are accustomed to, we have established these financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible. **PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW**.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance. Further it is the patient's responsibility to verify with your insurance that Dr. Meyer is a provider within your network.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist and we will give you a form to update.
3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, and Discover.
4. If your insurance does not pay within 45 days, you will be billed for any unpaid balance. If your insurance denies our charges, or does not pay us in a timely manner, you will be responsible for the balance owed.
5. If you do not pay your unpaid balance within 45 days from the date of the bill your account may be referred to a collection agency, and reported to the credit bureau.
6. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of the amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
7. HMO/PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service—no exceptions. If your plan requires you to have an authorization to see a specialist, it is your responsibility to make sure your primary care physician gets the proper referral from your insurance company to see Dr. Meyer. If we do not participate with your plan, we will verify your out-of-network benefits, file your charges, and will expect payment of your portion of the charges at the time of service.
8. SELF PAY PATIENTS: Patient with no insurance will be expected to pay at the time services are rendered.
9. No show or missed appointments- When an appointment is scheduled with Dr. Meyer or the physician assistant, time is specifically allocated for you. When an appointment is not canceled in advance, and the patient 'no shows', another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be time when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. If you miss your appointment without 24 hour cancellation notice, you will be charged a $25.00 fee.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of the charges for services rendered to you. If you have any questions regarding our financial policy, please contact our billing department at 713-484-6200 ext 106.

I have read and have a full understanding of the financial policy of Houston Center Spinal Reconstruction and Disc Replacement.

Patient Signature:__________________________________ Date:________________